BEFORE THE PERSONNEL APPEALS BOARD

STATE OF WASHINGTON

GAIL WILLIAMS, Appellant, v. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	Case No. DISM-02-0057 FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER OF THE BOARD

I. INTRODUCTION

1.1 **Hearing.** This appeal came on for hearing before the Personnel Appeals Board, WALTER T. HUBBARD, Chair, and GERALD L. MORGEN, Vice Chair. The hearing was held at the Department of Social and Health Services, 840 North Broadway, Everett, Washington, on August 12 and 13, 2003.

1.2 **Appearances.** Appellant Gail Williams was present and was represented by Christopher Coker, Attorney at Law, of Parr, Younglove, Lyman & Coker, P.L.L.C. Kara Larsen, Assistant Attorney General, represented Respondent Department of Social and Health Services.

1.3 **Nature of Appeal.** This is an appeal from a disciplinary sanction of dismissal for neglect of duty, gross misconduct and willful violation of agency rules and regulations. Respondent specifically alleged that Appellant misrepresented to her supervisor the seriousness of a child's

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

injuries, failed to properly investigate the child's condition and failed to follow agency policy regarding Child Protective Team (CPT) staffing prior to returning the child to her home.

II. FINDINGS OF FACT

2.1 Appellant Gail Williams was a permanent employee for Respondent Department of Social and Health Services. Appellant and Respondent are subject to Chapters 41.06 and 41.64 RCW and the rules promulgated thereunder, Titles 356 and 358 WAC. Appellant filed a timely appeal with the Personnel Appeals Board on July 25, 2002.

2.2 By letter dated July 23, 2002, Todd Henry, Regional Administrator for Region 3 Division of Children and Family Services, informed Appellant of her dismissal effective at the end of her work shift on August 9, 2002. Mr. Henry charged Appellant with the causes of neglect of duty, gross misconduct and willful violation of agency rules and regulations. Mr. Henry specifically alleged that Appellant misrepresented to her supervisor the seriousness of a child's injuries, failed to properly investigate the child's condition and failed to follow agency policy regarding Child Protective Team (CPT) staffing prior to returning the child home.

2.3 Appellant began her employment with the Department of Social and Health Services in January 1979, and she became a Social Worker 3 in August 1988. Prior to her dismissal, Appellant had a good performance record and had no previous disciplines of any type. Appellant's primary responsibility as a Social Worker 3 was to ensure the safety and health of children by conducting complete and thorough investigations of alleged child abuse and neglect.

2.4 The Children's Administration Practices and Procedures Guide outlines the circumstances under which a Child Protection Team (CPT) is to be utilized by a social worker. The policy requires social workers to consult with a Child Protective Team whenever necessary to make key

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

decisions about a child's case. A social worker can request a CPT when there is a dispute about the placement of a child or returning a child home. The policy specifically states that a CPT is utilized to:

> a) assist in assessment of the future risk of abuse and neglect to children; and
>
> b) assist in assessment of the need to place children in out-of-home care in [child abuse] cases where risk of serious harm to the child exists, including (but not limited to) the situations outlined below:
>
> - Any case in which there is serious professional disagreement … regarding risk of death, serious injury, out-of-home placement of a child, or the child's return home as a result of a decision to leave a child in the home or to return the child to the home;
> - Cases in which the risk assessment, following initial investigation, results in moderately high or high risk classification, and the child victim is age six or younger;
> - ….
> - Complex cases where such consultation will help improve outcomes for children.

2.5 Appellant was aware of and had received training on the DSHS and DCFS policies, practices, case management, and she had extensive hands-on experience conducting child abuse investigations.

2.6 On August 14, 2001, the Mt. Vernon Department of Children and Family Services received a referral from Skagit Valley Hospital claiming that 14-month old Anndrea D. had multiple cigarette lighter burns to her body. The burns to the child were inflicted on August 12, 2001. The child abuse referral indicated there was both physical abuse and medical neglect and was screened as "emergent, high standard of investigation, high risk."

2.7 On August 15, 2001, Sereta Williams, Appellant's supervisor, referred the case to Appellant. Excerpts from the Intake Summary Report for Referral for Anndrea, which Ms. Williams provided to Appellant, indicate as follows:

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

> ... child has a bruise on her face, 3 burns on her face, and burns on the rest of her body. … father Christopher alleges the child was being watched by his girlfriend Katie ... on Sunday, 8/12/01. Katie disclosed a "neighbor girl came over," and was playing with a lighter. Katie went to use the bathroom "for a few minutes" and heard some screaming … Katie … discovered Andrea bruised and with burn marks. …

2.8 As a part of the CPS investigation, Appellant visited Anndrea in the hospital to view her condition first-hand. Appellant observed numerous burns covered with bandages, and because the child was extremely upset and screaming, she did not have the bandages removed. Although Appellant was required to take photos in a physical abuse investigation, in this case, Appellant failed to take a camera to the hospital. Appellant later told her supervisor she would obtain photos from either law enforcement or the medical providers. However, Appellant never obtained the photos.

2.9 After observing the nature of Anndrea's burns, Appellant concluded they were non-accidental. In an entry in Anndrea's Service Episode Record (SER), Appellant wrote:

> The burns/marks on Anndrea were not blistered. The ones on her upper thighs were covered with bandages to prevent possible infection. She is a healthy looking, chubby, very entertaining little girl.

2.10 Although required to do so, Appellant did not describe in Anndrea's SER the nature of the burns, the number of burns or where the burns were located.

2.11 Appellant first met Chris, Anndrea's father on August 16, 2001. Based on their discussion, she felt confident that Chris was not responsible for Anndrea's injuries because he was not in the home when the burns were inflicted. Appellant also spoke with Chris' girlfriend, Katie, who assisted Chris in the care of Anndrea while Chris was at work.

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

2.12 Law enforcement officials were also conducting a simultaneous criminal investigation into Anndrea's abuse, and Appellant learned that the alleged perpetrator was a 10-year old girl who claimed she accidentally burned Anndrea with a lighter. Neither law enforcement nor Anndrea's physicians believed the burns were accidental.

2.13 After conducting a placement assessment, Appellant determined that Anndrea should be placed in protective custody with a foster parent. Under agency policy, the department had 72 hours from the date Anndrea was placed in protective custody, not including the weekend, to file a dependency petition (also referred to as a shelter care hearing). A dependency petition is initiated when the department reasonably believes there is a potential of further risk or harm (imminent danger) to the child if returned home. In this case, because the 72-hour period expired on the weekend, the department had until Monday, August 20, 2001 to file the dependency petition.

2.14 To help determine whether to return Anndrea home, Appellant contacted Anndrea's medical providers. Appellant spoke by telephone to Dr. Richard Levine. He indicated that all but one of the burns to Anndrea had the "outline/impression of the circle of the [lighter] wick that becomes the flame." When asked by Appellant whether he felt that Anndrea could be returned to the home, Dr. Levine informed Appellant that he was not comfortable expressing an opinion about whether it was safe to return Anndrea to the home. Dr. Levine also told Appellant that he was not comfortable stating that there was no neglect on Katie's part, but he felt that Chris had taken the appropriate steps by seeking medical attention for the burns.

2.15 Appellant was staffing Anndrea's case with her supervisor, Sereta Williams. They periodically spoke and communicated by email regarding Appellant's investigation. During one conversation, Appellant indicted to Ms. Williams that the burns to Anndrea was not serious enough

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

to require hospitalization, that Chris was willing to accept services from CPS to ensure the safety of Anndrea and that he was willing to sign a contract to that effect. Ms. Williams had concerns regarding Appellant's investigations into child neglect and abuse. Ms. Williams specifically believed that Appellant minimized the seriousness of cases, that she did not like to file dependency petitions because she did not like to involve herself in the work of going to court and that she removed children from the home only in extreme situations. As a result, Ms. Williams asked Appellant to get agreement from Anndrea's physicians that it was safe to return Anndrea home.

2.16 On August 16, 2001 Appellant spoke with Dr. Jeff Landesberg, who also viewed Anndrea's burns. Dr. Landesberg reiterated that the burns to Anndrea could not have occurred accidentally. Appellant asked Dr. Landesberg if he would agree with a plan to return Anndrea home with a contract prohibiting the 10-year old from having contact with Anndrea. Appellant explained that it was her practice to work with other professionals, including medical providers, as a team and that she wanted his input. Dr. Landesberg expressed that it was not his role as a medical provider to make any decisions about a CPS case plan, but that he would speak to Dr. Levine about the case.

2.17 On the morning of August 17, 2001, Appellant and Ms. Williams were exchanging emails regarding Anndrea's case. Appellant explained to Ms. Williams that Dr. Landesberg was unwilling to provide any statement to the effect that it was appropriate to return Anndrea home to the custody of her father. Appellant also wrote, "I think that he (Dr. Landesberg) and Levine would be willing to state that they don't think the father did this and Levine already said he thought if dad was willing to accept services that Anndrea should go home." Ms. Williams responded that she should have "him write what he said, i.e., that he doesn't think the father did this and that the child could be returned to the father if we offer and he accepts services."

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

2.18 On August 17, 2001, Appellant also received an email from Regina Patterson, a social worker who previously handled a case involving Anndrea, Chris and Katie. Ms. Patterson expressed her opinion that Appellant's proposed services contract would be okay with Chris. She also informed Appellant that Katie "had a rough childhood. She was molested and her mother basically was not too involved a parent."

2.19 On the afternoon of August 17, Appellant spoke to Dr. Levine again to discuss Anndrea's return to the home. Dr. Levine told Appellant he disagreed with the explanation of the injuries, that the story provided about the injuries was not consistent with the wounds and believed that anybody who took care of the child remained suspect. In his testimony before us, Dr. Levine credibility testified that Appellant indicated to him that she checked out the home, interviewed the father and felt Anndrea was safe in his care. Appellant mentioned that the father had been involved in another CPS case and that she had spoken to the other social workers that handled the case and based on their feedback, she felt it was safe to put Anndrea back in the home with father. Dr. Levine deferred to her expertise as a social worker to make the determination that returning Anndrea to the home was safe. Dr. Levine documented his discussion of August 17, and he wrote, in part:

> ... Gail said that she has worked with the father extensively, has reviewed his record, and based on this feels it is safe to allow Anndrea to come under his care again. Based on her evaluation I am in agreement. This being said, I feel strongly that the investigation as to the source of the burns needs to continue as I feel we have not defined an adequate explanation. She will pursue this. Public health nurse will be involved. She will forward the pictures and notes to Dr. Ken Feldman and this case will not be closed until an adequate explanation is obtained."

2.20 Prior to retrieving Anndrea from the foster home and returning her to her father, Appellant called Ms. Williams. Ms. Williams asked about the condition of Anndrea and about the burns. Appellant indicated that the child was safe, that the burns were superficial, were not blistering, and did not require hospitalization. Appellant further indicated that Anndrea's physicians were in

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

agreement that the child should be returned home. Appellant reassured Ms. Williams that the father would take care of and protect Anndrea. Appellant did not indicate to Ms. Williams that a CPT review was necessary and based on Appellant's assurances, Ms. Williams was also convinced that it was safe to return Anndrea to the home.

2.21 In a memo dated August 17, Appellant acknowledged that "Katie may have been neglectful by leaving Anndrea with the 10-year old for 'too long' but may be afraid to tell Chris that." Katie was paid by DSHS, under the Workfirst Program, to provide care for Anndrea. Appellant's SER notes do not express any other reservations about Katie's ability or suitability to continue supervising Anndrea.

2.22 Appellant concluded that it was safe to return Anndrea to her father's home. Appellant prepared a home support services plan and had Chris sign a contract with the agency. The contract specified that the 10-year old was to have no contact with Anndrea, but did not address Katie's role as a care provider. When Appellant returned the child to the home, Appellant spoke to Katie who started crying and admitted she had left the child alone the day the burns were inflicted even though she knew she was not supposed to leave Anndrea unattended.

2.23 Anndrea's medical notes indicate that she had burns "all over her body" ranging from first to second degree in severity, including three burns to her face, one on her abdomen, approximately six on her back, two on her left arm and three to four on each leg. The medical notes also reflect that Anndrea had a bruise under her left eye.

2.24 Several weeks after Anndrea was returned to the home, she was taken back to Skagit Valley Hospital. Medical personnel there examined Anndrea and determined the child had been the subject of abuse. Medical personnel contacted CPS to report their concerns that the child had been

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

returned to the care of her father despite concerns that it was possibly an unsafe environment. As a result, Appellant's new supervisor, Natalie Green, initiated two Conduct Investigation Reports against Appellant.

2.25 Todd Henry, Regional Administrator for Region 3 DCFS, was Appellant's appointing authority when the discipline was imposed. In reviewing whether Appellant engaged in misconduct, Mr. Henry reviewed the investigative reports of Appellant's actions on the Anndrea D. case, Appellant's written responses to the allegations and the findings of misconduct made by Paula Bentz, Area Administrator. Mr. Henry also reviewed Anndrea's case file, information provided by Anndrea's doctors, and the SER entries made by Appellant.

2.26 Prior to deciding the level of discipline, Mr. Henry met with Appellant on May 21, 2002 to discuss the allegations. After considering Appellant's responses, Mr. Henry concluded that Appellant neglected her duty in the handling of Anndrea's case when she failed to take photos of the burns, failed to properly examine and document the burns, and failed to obtain copies of Anndrea's medical records. Mr. Henry concluded that Appellant's failure to conduct a thorough investigation and her failure to conduct an adequate safety assessment constituted neglect of her duty as a social worker. Mr. Henry also concluded that Appellant neglected her duty and violated agency policy when she failed to request a CPT. Mr. Henry concluded that Appellant minimized and inaccurately described the seriousness of Anndrea's injuries when describing them to her supervisor.

2.27 Mr. Henry reviewed Appellant's tenure with the department, her credentials and training as a social worker. However, he was highly concerned that Appellant disregarded her duty to protect children by failing to err on the side of caution when making a decision to return a child home. Mr. Henry concluded that Appellant demonstrated a serious lack of judgment when she failed to have

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

Anndrea's case reviewed by a CPT despite the presence of professional disagreement in a "high risk" case. Mr. Henry determined that by failing to have Anndrea's case reviewed by CPT members and by not accurately and honestly describing the nature the child's injuries to her supervisor, Appellant interfered with the agency's mission to protect children, thereby engaging in gross misconduct. Mr. Henry ultimately concluded that dismissal was the appropriate sanction.

III. ARGUMENTS OF THE PARTIES

3.1 Respondent argues that Appellant failed to conduct a thorough and adequate investigation in the Anndrea D. case. Respondent asserts that the doctor's chart notes showed the injuries to Anndrea D. were non accidental and not consistent with the reasons given by the family. Respondent argues that Appellant failed to take photos of the child's injuries, made incomplete and inaccurate entries of the child's injuries, and failed to obtain the child's medical records. Respondent argues that Appellant also failed to adequately assess the risk to Anndrea by returning her to the home despite agency policy that required a CPT under the circumstances and because of the child's age. Respondent contends that Appellant, nonetheless, determined that the child could be returned home even though the 72-hour period had not expired. Respondent argues that Appellant minimized the injuries to the child and failed to provide accurate information about the doctor's opinions to her supervisor. Respondent argues that Appellant's investigation was so inadequate that it warranted dismissal despite Appellant's long tenure with the department.

3.2 Appellant asserts that she took all the appropriate and necessary steps and used her independent judgment as a social worker to ensure that Anndrea could be safely returned to the home. Appellant asserts that by all accounts, the perpetrator of the burns was a 10-year old child who did not live in the home and that she took all steps necessary to ensure the perpetrator had no further contact with Anndrea. Appellant asserts she conducted a visual check of the visible burns on Anndrea's body, and did not take the bandages off because it would have been inappropriate

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

under the circumstances and considering the child's demeanor. Appellant denies that she lied to her supervisor when describing Anndrea's condition. Appellant asserts that she was aware from the very beginning that the burns to Anndrea were serious and not accidental, but not so serious as to warrant hospitalization. Appellant further asserts that she consulted with her supervisor, who determined it was unnecessary to initiate a CPT. Appellant asserts that she went above and beyond what a social worker was required to do, and that while it was unfortunate that the child was abused again, that injury could not have been prevented.

IV. CONCLUSIONS OF LAW

4.1 The Personnel Appeals Board has jurisdiction over the parties and the subject matter.

4.2 In a hearing on appeal from a disciplinary action, Respondent has the burden of supporting the charges upon which the action was initiated by proving by a preponderance of the credible evidence that Appellant committed the offenses set forth in the disciplinary letter and that the sanction was appropriate under the facts and circumstances. WAC 358-30-170; Baker v. Dep't of Corrections, PAB No. D82-084 (1983).

4.3 Neglect of duty is established when it is shown that an employee has a duty to his or her employer and that he or she failed to act in a manner consistent with that duty. McCurdy v. Dep't of Social & Health Services, PAB No. D86-119 (1987).

4.4 Respondent has met its burden of proving that Appellant neglected her duty to conduct a thorough and accurate investigation of client Anndrea's CPS referral. Appellant both failed to photograph the injuries, adequately document the injuries and obtain the child's medical record. Appellant took short cuts in her investigation and she then justified her actions by stating that she was relying on photographs by either law enforcement or medical staff. Appellant also excused her

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

failure to make detailed entries about Anndrea's burn injuries into the child's SER because the medical reports would document those injuries; however, Appellant never obtained the medical reports to place in the child's CPS file.

4.5 Respondent has also proven by a preponderance of the credible evidence that Appellant failed to provide Ms. Williams with accurate and objective information about Anndrea D.'s case. Appellant understated and minimized the nature and seriousness of the child's burns. Later, Appellant attempted to mitigate the explanations and descriptions she gave her supervisor by claiming that they were not serious because they did not require the child to be hospitalized. However, the child's medical record clearly supports that her injuries were serious and that she had approximately 20 first and second-degree burns. While these burns did not require hospitalization, they nonetheless required medical treatment and follow-up and caused great consternation among the medical personnel that provided treatment to the child.

4.6 Willful violation of published employing agency or institution or Personnel Resources Board rules or regulations is established by facts showing the existence and publication of the rules or regulations, Appellant's knowledge of the rules or regulations, and failure to comply with the rules or regulations. Skaalheim v. Dep't of Social & Health Services, PAB No. D93-053 (1994).

4.7 Respondent has met its burden of proving that Appellant willfully violated the agency's policy, which requires that a Child Protection Team assist in assessing 1) whether a child should be place in out-of-home care where there is concern that the child will be seriously endangered if returned home or 2) where there is professional disagreement. A CPT was warranted here on both these criteria. First, Appellant should have questioned whether Anndrea could be safely placed back in the father's home when there was evidence that he and Katie both failed to seek immediate medical attention for the child. Furthermore, Katie's admission to Appellant that she left the

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

Anndrea unsupervised also called into question whether Katie was a suitable caretaker for the child. There was a question about whether either Chris or Katie could adequately protect the child; therefore, Appellant should have requested CPT review. Furthermore, a CPT was necessary because Anndrea was under the age of six and the risk assessment was high.

4.8 Secondly, Appellant was aware that both Dr. Levine and Dr. Landesberg raised serious concerns about the return of the child to home because they were dissatisfied with the explanation provided for the burns, because there was no clear evidence at the time that the 10-year old was the perpetrator; therefore, they felt that anyone in the household remained suspect. On the other hand, Appellant indicate it was safe to return the child to the father with a contract for services. There was clearly a professional disagreement between he social worker and the medical providers, which warranted a CPT review.

4.9 Gross misconduct is flagrant misbehavior that adversely affects the agency's ability to carry out its functions. Rainwater v. School for the Deaf, PAB No. D89-004 (1989). Flagrant misbehavior occurs when an employee evinces willful or wanton disregard of his/her employer's interest or standards of expected behavior. Harper v. WSU, PAB No. RULE-00-0040 (2002).

4.9 Respondent has met its burden of proving that Appellant not only failed to conduct a thorough and complete investigation into client Anndrea's abuse, but that she minimized the seriousness of the case to her supervisor and she failed to request a CPT. Appellant failed to carry out the agency's mission to keep the safety and well-being of children paramount, and her actions in this case violated the agency's high standards of social work and rises to the level of gross misconduct.

Personnel Appeals Board
2828 Capitol Boulevard
Olympia, Washington 98504

4.11 In determining whether a sanction imposed is appropriate, consideration must be given to the facts and circumstances, including the seriousness and circumstances of the offenses. The penalty should not be disturbed unless it is too severe. The sanction imposed should be sufficient to prevent recurrence, to deter others from similar misconduct, and to maintain the integrity of the program. Holladay v. Dep't of Veterans Affairs, PAB No. D91-084 (1992).

4.11 Mr. Henry had serious doubts about whether he could entrust Appellant with the task of properly investigating cases of child abuse. He ultimately determined, based on Appellant's unwillingness to accept responsibility for her deficient performance in this case and her failure to err on the side of caution, that it was in the best interest of the department to dismiss Appellant. Under the facts and circumstances of this appeal, we conclude that the sanction of dismissal was warranted. Therefore, the appeal of Gail Williams should be denied.

V. ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that the appeal of Gail Williams is denied.

DATED this _____ day of _____, 2003.

WASHINGTON STATE PERSONNEL APPEALS BOARD

_____
Walter T. Hubbard, Chair

_____
Gerald L. Morgen, Vice Chair

Personnel Appeals Board
2828 Capitol Boulevard
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